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Relationships between self-concept and resilience profiles in young people with disabilities

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Abstract

Introduction. The present study aims to identify different profiles in self-concept and resilience. In addition, statistically significant differences in self-concept domains among the profiles previously identified are analyzed.

Method. The AF5 Self-Concept Questionnaire (*Cuestionario de Autoconcepto AF5*) and the Resilience Scale were administered to 114 young people with different disabilities (physical, intellectual, visual, and auditory), aged between 18 and 35 years (M = 26.22; DT = 4.02).

Results. Cluster analyses enabled us to identify three different resilience profiles. Results also revealed statistically significant differences in resilience among the participants according to type of disability. This was also observed in most self-concept domains among profiles.

Discussion y Conclusion. Results suggest the need to deepen our knowledge of resilience and to design self-concept programs for people with disabilities.

Keywords: Young people with disabilities; Functional diversity; Resilience; Self-concept; Physical disability; Intervention programs

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Resumen

Introducción. En este trabajo se analiza el autoconcepto y la resiliencia en un grupo de jóvenes con discapacidad según la tipología y grado de discapacidad. Asimismo, se examina si existen combinaciones de los componentes de resiliencia que den lugar a diferentes perfiles resilientes. Finalmente, se comprueba si existen diferencias estadísticamente significativas entre los grupos obtenidos respecto al autoconcepto.

Método. La *Escala de Autoconcepto F5* y la *Escala de Resiliencia* fueron administradas a una muestra de 114 jóvenes con diferentes tipos de discapacidad (física, intelectual, visual y auditiva). El rango de edad fue 18 a 35 años (M = 26,22; DT = 4,02).

Resultados. El análisis de conglomerados identificó tres perfiles resilientes. Entre estos perfiles se encontraron diferencias estadísticamente significativas respecto a las dimensiones de autoconcepto.

Discusión y conclusión. Esto sugiere la importancia de diseñar programas que potencien la resiliencia, con objeto de desarrollar el autoconcepto entre los jóvenes con discapacidad.

Palabras Clave: jóvenes con discapacidad; diversidad funcional; capacidad resiliente; autoconcepto; programas de intervención.

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Introduction

There has been growing interest in improving self-concept in young people with disabilities through integration programs (Antle, 2004; Guest, Klose, Needham-Shropshire, & Jacobs, 1997; Pérez & Garaigordobil, 2007; Sánchez & López-Justicia, 2012; Sherer, Maddux, Mercandante, Prentice-Dunn, Jacobs, & Rogers, 1982). This construct is considered to be one of the most important variables present in the individual, for it is made up mainly of references, feelings and ideas that a person has about him/herself, which enables him/her to direct his/her life from an academic/professional perspective as well as from a personal one (Fuentes, García, Gracia, & Lila, 2011; García, Musitu, Riquelme, & Riquelme, 2011; García, Gracia, & Zeleznova, 2013; Goñi, Fernández-Zabala, & Infante, 2012).

Self-concept and disability

Hence self-concept is responsible for creating a framework of reference for interpreting external reality and one's own experiences, conditioning expectations and motivation, and in this way, contributing to health, to psychic balance (García, Musitu, Riquelme y Riquelme, 2011), and to the subjective well-being of the person (Polo-Sánchez & López-Justicia, 2012). All of this, which is essential in all individuals, is especially important in the most vulnerable groups, as is the case of young people who experience living with a disability (Morales, Fernández, Infante, Trianes, & Cerezo, 2010).

Figures published by the *EDAD* Survey on disability, personal autonomy and dependence, carried out by the National Institute of Statistics (2008) estimate that 163,650 disabled people of between 15 and 30 years of age live in Spain. In this regard, the International Classification of Functioning, Disability, and Health (World Health Organization, 2001) established that disability is the result of the interaction of a person who suffers from an impairment with physical and attitudinal barriers in his/her environment, made up of negative attitudes and prejudices, which are important obstacles in the way of his/her social inclusion (de Boer, Pijl, & Minnaert, 2010; Novo-Corti, Muñoz-Cantero, & Calvo-Porral, 2011; Suriá, 2014).

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In this sense, it is not only the attitude of the rest of society that determines the integration of disabled persons, but also the perception that one has about him/herself, that is, self-concept, which plays a crucial role, as it determines goals and expectations, and guides a person's behavior (Polo-Sánchez & López-Justicia, 2012). It is very likely that if a person sees him/herself in a negative light, this will result in a less unfavorable image and treatment by others than if he/she has a positive vision of him/herself (Morales et al., 2010). In relation to this, several studies (Buscaglia, 1990; Pérez & Garaigordobil, 2007; Polo-Sánchez & López-Justicia, 2012) indicate that, although self-concept in people with disabilities grows and develops in the same way as in people without impairment, its evolution is often not so robust due to the fact that the disabled person receives negative influences, often facing from childhood social rejection and negative experiences in interpersonal relationships which underestimate and frustrate them. These circumstances mean that there is more likelihood of developing a negative self-concept and therefore of needing to influence a group such as that of young people with disabilities, a group which is in an at-risk situation, firstly, because of their experience of living with a disability (Martínez, García, & Pérez, 2005; Matalinares et al., 2011; Suriá, García-Fernández, & Ortigosa, 2015), and secondly, because of the current phase of their life, an evolutionary period of the life cycle characterised by a greater differentiation of self-concept given that young people face new social and cognitive roles as well as notable physical and bodily changes, giving rise to the appearance of new dimensions of self-worth. All these changes, along with young people's greater vulnerability or their susceptibility to distorting their own image, explain the huge interest there is in studying self-concept at this period of the life cycle (Esnaola, 2009; Luna & Molero, 2013; Saavedra & Villalta, 2008).

Resilience and disability

In this area, numerous investigations have examined different variables which may be involved in the development of self-concept, some of the most outstanding ones being emotional intelligence (Rey & Extremera, 2012), pro-social behavior (Luna & Molero, 2013) empowerment (Silva-Dreyer & Martínez-Guzmán, 2007), and resilience (Matalinares et al., 2013), amongst others. Focusing on *resilience*, empirical evidence has shown this to be one of the determining factors in integration and in quality of life in general of people with disabilities (Gil-Llario, Molero-Mañes, Ballester-Arnal, & Sabater-Pavía, 2012; Gross-Fava & Tomba, 2009; Quiceno Sierra & Vinaccia, 2012; Saavedra & Villalta, 2008; Suriá, 2014). This term was coined by Rutter (1972), and is characterised as being the capacity of a person to

overcome adversity, recover and come out of the situation strengthened, enabling the development of social, academic, and vocational competences, in spite of being exposed to stressful situations and grave difficulties (Grotberg, 1995). From this definition we can deduce that resilience is a set of social and intra-psychic processes which occur over time, creating combinations among the person's attributes and his/her social and cultural environment, and is, therefore, an interactive process made up of different dimensions (Kotliarenco, 2000; Saavedra & Villalta, 2008; Uriarte, 2013).

A review of the literature on this construct indicates that there is no unanimity on limiting the number of its dimensions (Heilemann, Lee, & Kury, 2003; Oshio, Nakaya, Kaneko, & Nagamine, 2002; Rodríguez et al., 2009; Salgado, 2005; Wagnild & Young, 1993, to cite some authors), but there is agreement that resilient people as socially competent, that they are aware of their identity, that they can make decisions, establish goals and believe in a better future, satisfy their basic needs of affection, relationships and respect, and achieve their goals (Rybarczyk, Emery, Guequierre, Shamaskin & Behel, 2012; Saavedra & Villalta, 2008). Also, there is consensus on defining this concept as a set of social and intrapsychic processes which occur over time, creating combinations among the person's attributes and his/her social and cultural environment, which means therefore, that it is a dynamic process in which its different constituent dimensions interact (Kotliarenco, 2000; Saavedra & Villalta, 2008; Uriarte, 2013; Vinaccia, Quiceno & Moreno San Pedro, 2007).

Within the dimensions that make up resilience are Acceptance of self and life, Social Competence and Self-discipline. If we return to the notion of self-concept and the dimensions of which it is composed, we can find certain similarities in some of these, such as Self-acceptance and Positive relationships with others and the above-mentioned components of resilience. Therefore, there may exist a direct link between the components of both constructs, that is, between self-concept and resilience. On the other hand, if the two constructs are composed of different factors, this could mean that each of the components of resilience may not have the same relevance in self-concept.

Self-concept and resilience in disability

With regard to self-concept and its possible association with resilience in young people with different types of disabilities, at the present time there are no published studies which

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analyse in depth the relationship between the two constructs or examine the influence of the type and degree of disability in self-concept and resilience. Previous lines of research have stressed the importance of nurturing resilience in people with disabilities, given that it promotes emotional well-being, personal development, social inclusion, and quality of life (Gifre, Del Valle, Yuguero, Gil, & Monreal, 2010; Saavedra & Villalba, 2008; Suriá, 2014; Suriá et al., 2015). However, in the literature on this topic, there are no studies which identify and analyse the existence of combinations of the resilience components (Acceptance of life and self, Social Competence and Self-discipline), which may give rise to different profiles in these young people. Finally, the authors of this study are unaware of any published investigation into differences in self-concept in the various resilience profiles of young people with different types of disability, which take into account not only general self-concept but also other self-concept dimensions (e.g., academic/professional, social, emotional, etc.).

Objectives

Based on these considerations, the present study proposes three objectives. *First:* to deepen our knowledge about self-concept and resilience in a sample of young people with disabilities. To that end we will analyse the typology and degree of severity of the disability. *Second:* to ascetain whether there are combinations of different dimensions of resilience in the participants giving rise to different profiles, which may be identified according to the weighting each one of the dimensions has within each profile. *Third:* once we have found and defined the resilience profiles, we conduct analyses in order to find out if there are statistically significant differences amongst the resilience profiles defined and the different degrees of self-concept.

Method

Participants

For reasons of accessiblity, our study was conducted with an intentional sample of 114 young people with disabilities, all belonging to different associations devoted to helping disabled people. Initially, the population of the study was made up 132 young people. However, of these, 114 were willing to participate (see Table 1), 53.5% of whom were females and 46.5% were males, aged between 18 and 37 years (M = 28.22; SD = 4.02). They were classified depending on the type of disability sustained: 32.5% had a motor disability; 21.9% were

affected by an intellectual impairment; 22.8% were visually impaired, and the hearing of 22.8% was impaired. At the same time, depending on the degree or severity of the disability, it was observed that 36.8% of the participants had more than 65% disability, 38.6% had between 33% and 65%, while less than 24.6% of those who took part suffered from less than 33% of disability. As regards the time of life at which the disability had come on, 42.10% of the participants had been affected since birth while for 57.90% the onset of the disability had occurred later.

Table1. *Socio-demographic profile*

Sociodemographic profile		N	%
Gender	Female	61	53.5
	Male	53	46.5
Age in years	18-22	19	16,7
	23-27	40	35.1
	28-32	32	28.1
	33-37	23	20.2
Type of disability	Intellectual	25	21.9
	Auditory	26	22.8
	Motor	37	32.5
	Visual	26	22.8
Degree of disability	Less than 33%	28	24.6
	Between 33% and 65%	44	38.6
	More than 65%	42	36.8
Stage at onset of disability	Birth	48	42.1
	Later stage	66	57.9
	Total	114	100.0

Instruments

Socio-demographic Questionnaire. The authors devised an *ad hoc* questionnaire for collecting socio-demographic data about the participants: gender, age, type and severity of their disability.

Resilience Scale (Wagnild & Young, 1993). In its adapted version participants rate their agreement with statements on a Likert-type scale, from 1 (= in total disagreement), to 7 (= in total agreement). Higher scores indicate greater resilience, with scores ranging from 25 to 175 points. In order to determine the level of resilience prevelant in the participants, the researchers followed the same procedure as Heilemann, Lee, and Kury (2003). Scores greater than 147 would indicate high resilience; between 121 and 146, moderate resilience; scores lower than 121, low resilience. This scale was used because it is straightforward to apply, because it has been validated in a young adult population, and finally, because of the

psychometric properties it has shown in both the original (Wagnild & Young, 1993) and Spanish (Heilemann et al., 2003) versions, with internal consistencies of α = .89 and α = .93, respectively. In the present study, exploratory factorial analysis explained 81.20% of the variance, distributed in three differentiated factors:

Factor 1. *Personal competence,* understood as the recognition of factors of personal capacity, independence, mastery, perseverence, skills, etc. This factor is made up of 13 attributes and explained 35.37% of the variance

Factor 2. *Acceptance of self and life,* as a synomym of adaptation, flexibility, etc., composed of 6 attributes, which explained 24.42% of the variance

Factor 3. *Self-discipline,* with a factorial loading of 21.40%, which made up the remaining 6 items. Although the original version of the instrument yielded two factors, in the present study, as in other research in which the original version was used (Rodríguez et al., 2009; Suriá, 2012; Vara & Rodríguez, 2011), a third factor was obtained which we called "*Self-discipline"*. Additionally, internal consistency as measured by Cronbach's alpha coefficient was satisfactory (α = .88).

Escala de Autoconcepto Forma 5 (AF-5) (Five-Factor Self-Concept Questionnaire) by García and Musitu (1999). The AF-5 stems from a multidimensional consideration of Self-concept, the perspective which has most empirical support at the present time. This instrument is based on Shavelson, Hubner and Stanton's (1976) theoretical model, and consists of 30 items distributed among five dimensions: academic/work (items 1, 6, 11, 16, 21 and 26), social (items 2, 7, 12, 17, 22, and 27), emotional (items 3, 8, 13, 18, 23, and 28), family (items 4, 9, 14, 19, 24, and 29), and physical (items 5, 10, 15, 20, 25, and 30); that is, six items per demension. Participants respond to the items on a Likert-type scale, expressing their most positive to their most negative connotation for each item (from 1 = in total disagreement, to 5 = in total agreement). In this way, the scores on the questionnaire range from a minumum of 30 to a maximum of 150 (the higher the score, the more positive the self-concept).

This scale was chosen because it has been used in other studies involving participants whose characteristics were similar to those in the present research (Gómez-Vela, Verdugo, & González-Gil, 2007). It is easy to administrate and it may be applied to children and adults of different academic levels. What is more, the factorial structure of the items satisfactorily confirmed the theoretical dimensions, the components explaining 51% of the total variance

(with a Cronbach's alpha coefficient of .84). Regarding the psychometric properties of the scale for the present investigation, the internal consistency analysis indicated adequate reliablity (α = ,76). What is more, the explained 60.04% of the variance.

Procedure

Our research was a transversal study of a series of cases. The scales were administered to the participants, who belonged to several associations. In order to request the participation of persons with motor impairment, the researchers applied to the *Asociación de Parapléjicos y Personas con Gran Discapacidad Física, ASPAYM* (Association of Paraplegic Persons and Persons with Major Physical Disabilities). To request the participation of people with intellectual disabilities, the researchers approached the *Asociación Pro-Discapacitados Psíquicos de Alicante*, APSA (Association for Intellectually-Disabled People of Alicante, Spain). For the purpose of collecting data about hearing-impaired persons, the researchers applied to the *Asociación de Padres y Deficientes Auditivos de Alicante, APANAH* (Alicante Association of Hearing-Impaired Persons and their Parents). Finally, researchers contacted the *Organización Nacional de Ciegos Españoles, ONCE* (National Organization for Spanish Blind People), to request the participation of visually-impaired persons.

After contacting the directors of the associations to explain the objectives of the study, the researchers requested that members take part, and attended their regularly-held meetings. After giving their written consent, participants voluntarily and anonymously completed the questionnaires in the presence of the researchers. As regards the consent of intellectually-challenged participants, the questionnaires were administered taking into account the impairment of each one. Completion of the two scales took approximately 30 minutes. Raters had been trained previously in the application of the instruments. Data were gathered between March and December, 2014.

Data analysis

Frequencies and percentages were calculated for the socio-demographic data. In order to ascertain whether there were statistically significant differences in self-concept and in resilience depending on the type and degree of disablement severity, the authors used analysis of variance (ANOVA). Previously, the homoscedasticity of variance, normality of distribution, and independence of the variables were assured, using Levene's test, the Kolmogorov-

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Smirnov test, and the Chi-square test, respectively. In addition, the effect size was calculated (typified mean difference, or *d* index, Cohen, 1988), which indicates whether the magnitude of the differences encountered is small, moderate or large.

Two-step cluster analysis was used to identify resilience profiles. This is an exploratory tool designed to reveal natural groupings within a data set which otherwise would not be apparent. Also, this procedure can automatically determine an optimum number of clusters. Profiles were determined based on different combinations of the three dimensions of resilience assessed by Wagnild and Young's (1993) Resilience Scale: Personal competence, Acceptance of self and life, and Self-discipline.

Analyses of covariance (ANCOVA) on the clusters obtained were then conducted for the purpose of analysing the statistical significance of differences existing among groups in Self-concept factors. The age covariate was controlled in order to reduce its possible effects on results. Finally, *post hoc* tests were carried out to identify among which groups differences were found. Scheffé's method was applied as each group was not made up of the same number of participants.To analyse the magnitude or effect size of these differences, the direct eta^2 index was used. In addition, the effect size of differences observed was calculated (typified mean difference, or *d* index, Cohen, 1988). Data were analysed by means of SPSS statistical package version 19.0.

Results

Self-concept and Resilience depending on the type and degree of disability

On examining the mean scores for self-concept among the groups, it was observed that the participants presented moderate scores on the scale. No statistically significant differences were found according to type [$F_{(3,110)} = 0.35$, $p = .986$], or to degree of severity of the impairment [$F_{(2,111)} = 1.96$, $p = .148$].

As far as resilience is concerned, high levels of this capacity were found among the participants, with higher levels in young people with visual impairment and in those with motor disabilities [$F_{(3,110)} = 3.859$, $p = .042$]. In the *post hoc* analysis a large effect size in the visually impaired group ($d = 0.69$) and in the hearing- and intellectually-impaired group ($d =$

0.72) were noted, as well as in the comparison of the group with motor disability with the group of hearing (d = 0.57) and intellectual impairment (d = 0.54). However, no statistically significant differences depending on impairment's degree of severity were encountered [$F_{(2,111)}$ = 1.713, p = .186].

Tabla 2. *Means and standard deviations obtained in self-concept and in resilience depending on type and degree of severity of disablement*

Type/degree of disablement	Self-concept		Resilience	
	M	*SD*	*M*	*SD*
Intellectual	103.05	20.62	123.90	40.62
Hearing	100.43	19.35	123.43	22.80
Motor	97.83	26.23	148.97	23.35
Visual	101.94	23.49	153.33	14.86
Total	101.66	25.58	136.46	30.54
F	0.35		3.859*	
Less than 33%	101.50	27.83	141.09	27,77
From 33% to 65%	95.32	25.34	138.07	26,61
Greater than 65%	93.29	22.51	130.19	34,83
Total	105.66	25.58	136.33	30.44
F	1.960		1713	

Note. ** = .001 significance level; * = .05 signficance level.

Identification of resilience profiles

The cluster method, seeking to achieve maximum homogeneity in each group and the greatest differences among them, identified three groupings in the resilience dimensions. Resilence merged in this way in the first group (Low Personal competence-Low Self discipline-Low Acceptence of self and life, LP-LS-LA), which was made up of 28 participants (24.56%), and characterized by low scores on the three resilience dimensions. The second cluster (High Personal competence-High Acceptence of self and life-Low Self discipline, HP-HA-LS) was composed of 41 participants (35.96%), who presented high scores on Personal competence and on Acceptance of self and life, and low ones on Self discipline. In the third cluster (High Personal competence-High Acceptance of self and life-High Self discipline, HP-HA-HS), constituted by 45 persons (39.47%), there was a predominance of high scores on the three dimensions of the resilience scale.

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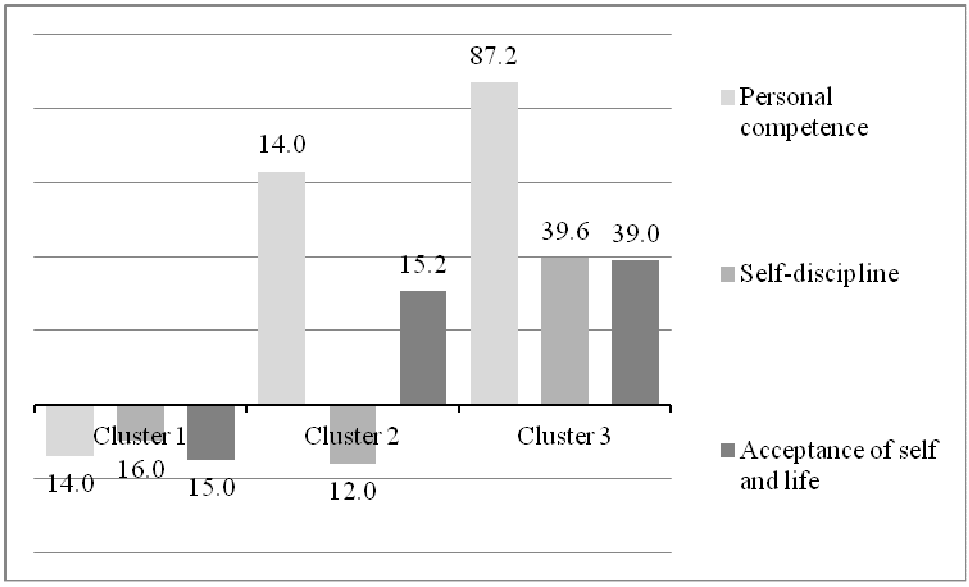

Figure 1. Graphic representation of the three-cluster model. Cluster 1: LP-LS-LA (Low resilience); Cluster 2: HP-HA-LS (High Personal competence, High Acceptance of self and life, and Low Self discipline); Cluster 3: HP-HA-HS (High resilience).

Inter-group differences in self-concept dimensions

Results pointed to the existence of statistically significant differences depending on the resilience clusters ($\lambda = 0.540$, $F = 5.779$, $p < .000$). No influence of the age covariate was observed ($\lambda = 0.097$, $F = 2.100$, $p = .978$).

Regarding mean scores on the *global self-concept scale*, we recorded statistically significant differences in the three groups or clusters [$F_{(2,111)} = 7.34$, $p < .05$, $\eta^2 = .10$], observing that Group 3 (HP-HA-HS) presented means higher than those of Group 2 (HP-HA-LS), ($d = 0.11$) and of Group 1 (LP-LS-LA) , ($d = 0.90$). Also, Group 2 (HP-HA-LS) showed higher mean scores than Group 1 (LP-LS-LA), ($d = 0.71$).

Examination of the different factors composing self-concept and *post hoc* comparisons made in order to ascertain amongst which groups differences existed, yielded the following results:

As regards Factor 1, *Academic/work self-concept*, the Group who presented high scores on the three resilience dimensions (Group 3, HP-HA-HS), had significantly higher means than Group 2, (HP-HA-LS) and Group 1 (LP-LS-LA), [$F_{(2,111)} = 4.49$, $p < .05$, $\eta^2 = .04$]. In the *post hoc* analysis between Group 3 (HP-HA-HS) and Group 2 (HP-HA-LS), the effect size was moderate ($d = 0.21$), and higher when comparing Group 3 (HP-HA-HS) with

Group 1 (LP-LS-LA), (d = 0.73). Group 2 (HP-HA-LS) presented higher scores than Group 1 (LP-LS-LA), (d = 0.55).

As far as Factor 2, *Social Self-concept*, is concerned, we noted statistically significant differences among the clusters [$F_{(2,111)}$ = 3.79, p < .05, η^2 = .03], finding that the group who yielded highest scores on the three resilience dimensions, that is, Group 3 (HP-HA-HS), as well as the group in which mean scores were high on Social competence and on Acceptance of self and life, Group 2 (HP-HA-LS), presented higher scores on Social self-concept than the group who had low scores on these dimensions, Grupo 1 (LP-LS-LA). In this way, Group 3 showed significantly higher means in comparison to Group 1 (d = 0.84). Similarly, Group 2 (HP-HA-LS) showed higher means than Group 1 (LP-LS-LA), (d = 0.54) on this self-concept factor.

Similar tendencies were found in Factor 3, concerning *Family Self-concept*, and in Factor 4, *Emotional Self-concept*. In Factor 3, concerning the family, we noted that Group 3 (HP-HA-HS) presented higher scores than Grupo 1 (LP-LS-LA), [$F_{(2,111)}$ = 17.55, p < .001, η^2 = .34], (d = 1.24), and than Group 2 (HP-HA-LS), (d = 0.82). In the same way, Group 2 (HP-HA-LS) gave showed means that were higher than those of Group 1 (LP-LS-LA), (d = 0.62). As far as Factor 4 was concerned, *Emotional Self-concept*, statistically significant differences were also revealed among the three clusters, especially as regards Group 3 (HP-HA-HS), with mean scores that were greater than those of Group 1 (LP-LS-LA), [$F_{(2,111)}$ = 9.50, p < .001, η^2 = .40, d = 0.90], and Group 2 (HP-HA-LS), whose mean scores were higher than those of Group 1 (LP-LS-LA), (d = 0.87).

Tabla 3. *Means and standard deviations obtained by the three groups, and eta-squared (η^2) values for each one of the self-concept dimensions*

Self-concept factors	Group 1 (LP-LS-LA)		Group 2 (HP-HA-LS)		Group 3 (HP-HA-HS)		Total		*F*	*p*	*η2*
	M	*DT*	*M*	*DT*	*M*	*DT*	*M*	*DT*			
Academic/work	22.20	(5.69)	25.45	(5.98)	26.00	(4.52)	24.14	(5.92)	4.49	.014	.36
Social	20.39	(4.56)	24.57	(5.28)	22.80	(4.48)	20.45	(5.01)	3.79	.047	.28
Family	21/07/16	(4.59)	27.79	(6.13)	23.60	(3.75)	24.55	(6.17)	17.55	.000	.52
Emotional	21.32	(6.10)	27.21	(7.11)	26.00	(4.52)	24.62	(7.02)	9.5	.000	.40
Physical	21.51	(5.72)	22.11	(4.86)	21.20	(5.03)	022.05	(5.33)	2.82	.064	.14
Total	106.49	(23.02)	123.13	(23.23)	125.60	(19.20)	116.42	(24.10)	7.34	.001	.33

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Discussion and conclusions

In our study we attempted to deepen our knowledge about the relationship between self-concept and resilience in young people who had different kinds and degrees of disability. To this end we posed several objectives. After the examination of levels of self-concept and of resilience in a population of young people with various impairments, results suggest that the participants had moderate levels in both constructs. These outcomes support ideas put forward by other authors who highlight the struggle that disabled people undertake in order to successfully cope with obstacles originating in their impairments (Morales et al., 2010; Saavedra & Villalta, 2008; Suriá, 2014).

Regarding resilience results depending on the type of disability, these indicate that the highest scores were given by young people with motor and visual impairments, while those with hearing and intellectual difficulties brought to light lower scores. One explanation for these outcomes may be the effect that the visibility of the former types of impairment generate in society. For several years now, from various social and political institutions, social inclusion of disabled people has been promoted, and with it, the raising of society's awareness of the importance of supporting the full psychosocial integration of persons who live with these difficulties (Floyd, Zambrano, Antó, Jiménez, Solórzano, & Díaz, 2012; Suriá, 2012, Thompson et al., 2010**)**. This is reflected in the most obvious disabilities, for example, motor or visual impairments. Hence, regardless of whether the disabled person makes use of any help available, s/he will perceive that s/he has support. On the other hand, some impairments are less visible, such as learning or hearing difficulties, which in many cases go unnnoticed by society. This means that others are not so involved in offering help, and so the person with this kind of problem may feel that s/he is less protected (Aguado & Alcedo, 2012; Juárez-Sánchez et al., 2010; Schalock, 2013).

The other variable taken into consideration in this first *first objective* was the influence of the degree of disability on self-concept and on resilience. In this regard, the results do not reflect the influence of this variable, but support the definition of resilience. In this way, taking into acount the definition of resilience itself and if this capacity develops as the individual comes across obstacles and overcomes them, this could explain that there are no

differences among groups in accordance with the severity of his/her disability. The constraints that these persons must face provide opportunities to increase this strength, for which reason, a greater degree of disability may generate a greater capacity to cope, and with it, the lack of differentiation in the degree of resilience seen in participants with lower levels of disability. In addition, individuals, regardless of their impairment's degree of severity, who take the initiative of seeking out support in associations and in self-help groups, may be more disposed to overcome hurdles, giving rise to the fact that most of the participants show quite high levels of resilience.

Similarly, self-concept is not seen to be affected by the degree of disability. In this regard, stereotypes and fashions prevalent in society unfortunately distance disabled persons from accepted canons of beauty (Matalinares, et al., 2013; Suriá et al., 2015). This could have repercussions in lower levels of self-concept in young people.

Our *second objective* was to analyse possible combinations of resilience dimensions in the young people who took part in the study, with the aim of identifying different resilience profiles. So, by means of cluster analysis, three distinct profiles were distinguished: one group with a profile of high scores on the three resilience components (HP-HA-HS), a second group with high scores on Social competence and on Acceptance of self and life, and low ones on Self-discipline (HP-HA-LS), and a third profile with low scores on all dimensions, that is, on Social competence, on Self-discipline, and on Acceptance of self and life (LP-LS-LA). These outcomes confirm therefore the second hypothesis posed concerning differences in resilience profiles depending on the weighting of resilience dimensions. If we observe the number of participants who make up each of the clusters, results show that the group with highest scores on the three dimensions, (HP-HA-HS), is the one that is made up of the largest number of individuals in comparison to the rest of the groups. This suggests, first, that a large percentage of the young people with disabilities analysed display high levels of resilience on the three dimensions. At the same time, the fact that another two groups with different profiles have been identified suggests that disabilities may nurture differing patterns of resilience. Finally, there emerged a group or profile of low resilience on the three dimensions. This profile may be have to do with deficits in psychological adjustment and with quality of life in general and therefore, with the fact that not all individuals who live with disability are well adjusted and adapted to living in this situation (Gifré et al., 2010; Saavedra &Villalba, 2008; Suriá et al., 2015).

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With reference to the *third objective*, results support the third hypothesis put forward, that is, the mean scores of the clusters recorded reveal statistically significant differences in self-concept. These data evince the existence of different profiles of resilience and help us to understand the relationship between resilience and self-concept. In this way, outcomes suggest that in most of the self-concept factors, groups who score highly on the three resilience dimensions stand out, as well as clusters in which Social competence and Acceptance self and life dimensions display high scores. In this area, several authors agree on the essential role played by resilience in the life of people who face adversity, as may be the case in young disabled people. It is therefore coherent to find links among dimensions which make up this construct as well as self-concept (Gross-Fava & Tomba, 2009; Suriá et al., 2015).

These outcomes are reinforced by the effect size, which indicated that in most of the self-concept factors, the magnitude of these differences is high in participants with low scores on the resilience dimensions. This is observed in factors related to the development of personal skills (academic/work self-concept), as well to sociability (social self-concept and family self-concept). In these factors, it is seen that the groups with high scores on the resilience dimensions of Social competence and Acceptance of self and life display higher mean scores. This means that young people with little resilience seem to encounter greater difficulties as regards social and family relationships as well as to experience poorer adjustment and adaptation to their environment.

In this regard, Social/personal competence is defined as behaviour displayed by an individual in an interpersonal context, conveying feelings, attitudes, opinions or rights, in a way befitting the situation (Caballo & Verdugo, 2013). In a similar fashion, Acceptance of self and life refers to belief in onself and to the recognition of one's own strengths and limitations in order to cope adequately with life's circumstances (Branden, 1995). Taking into account these definitions, previous studies link the construct of self-concept to positive interpersonal relationships (Bisquerra-Alcina & Pérez-Escoda, 2012) and with social functioning (Lacunza & de González, 2011), aspects which are closely connected to Social/personal competence and to Acceptance of self (García et al., 2011). This connection

would account for the results when examining factors related to academic/work self-concept and to social interactions such as social and family self-concept.

Finally, examination of the physical self-concept factor reveals that it does not differ across the three resilience profiles (High resilience group, Low resilience group, and High competence, high self-discipline and low acceptance group). Unfortunately, stereotypes and fashions prevalent in society may distance disabled persons from accepted canons of beauty (Matalinares, et al., 2011; Suriá et al., 2015). This could bring about lower levels of self-esteem in the physical self-concept factor.

Therefore, as our results reflect, it seems that resilience is related to characteristics which make up self-concept, and consequently, delving further into this association will favour suitable adaptation and integration of young people with disabilities into their environment (Caballo & Verdugo, 2013; Gifré et al., 2010; Saavedra & Villalta, 2008). Even so, we must take into account some *limitations* of this study. The main one is that we must not forget that the experience of disability is unique for each person, and that it will be made up of a complex combination of factors (stemming from different personal experiences, temperamants, and contexts), which we could have taken into account when explaining the variability of the profiles of resilience and of self-concept.

It is also likely that the young disabled people who took part in the investigation were more able to overcome their hurdles and were more motivated to participate than individuals who were reluctant to collaborate. In fact, it is logical to suppose that young people who belong to associations offering support are more likely to strengthen their resilience and self-concept, as belonging to them and attending meetings in search of informative, practical and emotional support, indicates their wish to search for ways of surmounting their difficulties. These aspects might overestimate the degree of resilience and of self-concept encountered and could bias the magnitude of some of the associations found. In future investigations, these biases should be controlled in order to improve the internal validity of the results.

In spite of these limitations, we consider that the results of our research are valuable as they suggest that, even though resilience is related to better adjustment of young disabled people in interpersonal and social development, not all the dimensions of resilience have the same weighting in this adjustment. This could be of importance in the design and application

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of programs for training and development of resilience skills, since this pattern leads to a higher self-concept among young people, for which reason we propose as a future objective to contine to delve into the relationship between resilience in young disabled people and their self-concept.

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